Psychiatry Integrated Primary Care

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Outline

1. Why we need psychiatry in primary care?
2. Why we need primary care in psychiatry?
3. Why we can not afford not to integrate?
4. What is Psychiatry Integrated Primary Care
5. Will it work financially?
6. What do patients think?

Penobscot Community Health Care

Way Behind

- 1963 Community Mental Health Center Act
- President Kennedy "return mental health care to the mainstream of American medicine."
- Idea was Community Mental Health Centers organized around hospitals, providing close collaboration between medical and community-based mental health
- Yet to be fulfilled

Lebensohn ZM. General hospital psychiatry USA: retrospect and prospect. Compr Psychiatry 1980;21(6):500–9.

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Table 1. Lifetime prevalence of DSM-IV/WMH-CIDI disorders by sex and cohort[1] (n=9282)

Lifetime	Total		Sex				Cohort							
			Female		Male		18-29		30-44		45-59		60+	
	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE
I. Anxiety Disorders														
Panic disorder	4.7	(0.2)	6.2	(0.3)	3.1	(0.3)	4.2	(0.5)	5.9	(0.6)	5.9	(0.4)	2.1	(0.4)
Agoraphobia without panic	1.3	(0.1)	1.6	(0.2)	1.1	(0.2)	1.2	(0.3)	1.4	(0.2)	1.8	(0.3)	0.9	(0.2)
Specific phobia	12.5	(0.4)	15.8	(0.6)	8.9	(0.6)	13.0	(0.9)	13.9	(0.7)	14.4	(1.0)	7.7	(0.6)
Social phobia	12.1	(0.4)	13.0	(0.6)	11.1	(0.6)	13.3	(0.7)	14.5	(0.9)	12.6	(0.9)	6.8	(0.5)
Generalized anxiety disorder	5.7	(0.3)	7.1	(0.3)	4.2	(0.4)	4.3	(0.4)	6.5	(0.5)	7.6	(0.7)	4.0	(0.4)
Post-traumatic stress disorder[2]	6.8	(0.4)	9.7	(0.7)	3.6	(0.3)	6.3	(0.6)	8.1	(0.9)	9.2	(0.8)	2.8	(0.5)
Obsessive-compulsive disorder[3]	2.3	(0.3)	3.1	(0.5)	1.6	(0.3)	3.1	(0.7)	3.0	(0.9)	2.4	(0.8)	0.6	(0.3)
Adult/Child separation anxiety disorder[2]	9.2	(0.4)	10.8	(0.6)	7.4	(0.5)	12.4	(0.9)	11.1	(0.7)	9.2	(0.8)	3.1	(0.5)
Any anxiety disorder[5]	31.2	(1.0)	36.4	(1.1)	25.4	(1.2)	32.9	(1.3)	37.0	(1.5)	34.2	(1.7)	17.8	(1.4)
II. Mood Disorders														
Major depressive disorder	16.9	(0.5)	20.2	(0.5)	13.2	(0.8)	16.0	(0.8)	19.3	(0.9)	20.1	(1.2)	10.7	(0.7)
Dysthymia	2.5	(0.2)	3.1	(0.3)	1.8	(0.2)	1.8	(0.3)	2.8	(0.4)	3.8	(0.6)	1.3	(0.2)
Bipolar I-II-sub disorders	4.4	(0.3)	4.5	(0.3)	4.3	(0.4)	7.0	(0.8)	5.3	(0.4)	3.7	(0.4)	1.3	(0.3)
Any mood disorder	21.4	(0.6)	24.9	(0.6)	17.5	(0.9)	22.6	(1.0)	24.5	(1.0)	24.2	(1.2)	12.2	(0.9)
III. Impulse-control Disorders														
Oppositional-defiant disorder[4]	8.5	(0.7)	7.7	(0.9)	9.3	(0.8)	9.9	(1.0)	7.3	(0.8)	--	--	--	--
Conduct disorder[4]	9.5	(0.8)	7.1	(0.9)	12.0	(1.0)	10.8	(1.1)	8.4	(0.7)	--	--	--	--
Attention-deficit/hyperactivity disorder[4]	8.1	(0.6)	6.4	(0.7)	9.8	(1.0)	7.8	(0.8)	8.3	(0.8)	--	--	--	--
Intermittent explosive disorder	7.4	(0.4)	5.7	(0.4)	9.2	(0.6)	12.6	(1.1)	8.8	(0.7)	5.3	(0.5)	2.4	(0.5)
Any impulse control disorder[4]	25.0	(1.1)	21.6	(1.4)	28.6	(1.5)	27.0	(1.6)	23.4	(1.1)	--	--	--	--
IV. Substance Disorders														
Alcohol abuse with/without dependence[2]	13.2	(0.6)	7.5	(0.5)	19.6	(0.9)	14.5	(1.0)	16.4	(1.1)	14.1	(1.0)	6.3	(0.7)
Drug abuse with/without dependence[2]	8.0	(0.4)	4.8	(0.4)	11.6	(0.7)	11.1	(0.9)	12.1	(1.0)	6.8	(0.7)	0.3	(0.1)
Nicotine dependence[2]	29.6	(0.8)	26.5	(1.3)	33.0	(1.0)	26.5	(1.8)	29.4	(1.5)	34.3	(1.6)	27.3	(1.7)
Any substance disorder[2]	35.3	(0.9)	29.6	(1.3)	41.8	(1.1)	33.2	(1.9)	37.1	(1.8)	39.8	(1.5)	29.6	(1.7)
V. Any Disorder														
Any[5]	57.4	(1.1)	56.5	(1.5)	58.4	(1.4)	58.7	(2.2)	63.7	(1.9)	60.0	(1.6)	44.0	(2.3)

[1]This table includes updated data as of July 19, 2007. Updates reflect the latest diagnostic, demographic and raw variable information.

[2]Assessed in the Part II sample (n = 5692).

[3]Assessed in a random one-third of the Part II sample (n = 2073).

[4]Assessed in the Part II sample among respondents in the age range 18-44 (n = 3197).

[5]Estimated in the Part II sample. No adjustment is made for the fact that one or more disorders in the category were not assessed for all Part II respondents.

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http://www.hcp.med.harvard.edu/ncs/ftpdir/table_ncsr_LTprevgenderxage.pdf

Table 2. 12-month prevalence of DSM-IV/WMH-CIDI disorders by sex and cohort[1] (n=9282)

12-month	Total		Sex				Cohort							
			Female		Male		18-29		30-44		45-59		60+	
	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE
I. Anxiety Disorders														
Panic disorder	2.7	(0.2)	3.8	(0.3)	1.6	(0.2)	2.8	(0.4)	3.7	(0.5)	3.1	(0.4)	0.8	(0.2)
Agoraphobia without panic	0.9	(0.1)	0.9	(0.2)	0.8	(0.2)	1.0	(0.2)	0.8	(0.2)	1.2	(0.3)	0.4	(0.1)
Specific phobia	9.1	(0.4)	12.2	(0.5)	5.8	(0.5)	10.3	(0.8)	9.7	(0.6)	10.3	(0.9)	5.6	(0.5)
Social phobia	7.1	(0.3)	8.0	(0.5)	6.1	(0.5)	9.1	(0.7)	8.7	(0.7)	6.8	(0.6)	3.1	(0.3)
Generalized anxiety disorder	2.7	(0.2)	3.4	(0.2)	1.9	(0.3)	2.0	(0.3)	3.5	(0.3)	3.4	(0.3)	1.5	(0.3)
Post-traumatic stress disorder[2]	3.6	(0.3)	5.2	(0.4)	1.8	(0.3)	4.0	(0.5)	3.5	(0.5)	5.3	(0.6)	1.0	(0.2)
Obsessive-compulsive disorder[3]	1.2	(0.3)	1.8	(0.5)	0.5	(0.2)	1.5	(0.4)	1.4	(0.6)	1.1	(0.6)	0.5	(0.3)
Adult separation anxiety disorder[2]	1.9	(0.2)	2.1	(0.2)	1.7	(0.3)	4.0	(0.5)	2.2	(0.3)	1.3	(0.3)	0.1	(0.1)
Any anxiety disorder[5]	19.1	(0.7)	23.4	(0.8)	14.3	(0.8)	22.3	(1.0)	22.7	(1.0)	20.6	(1.3)	9.0	(0.8)
II. Mood Disorders														
Major depressive disorder	6.8	(0.3)	8.6	(0.4)	4.9	(0.4)	8.3	(0.4)	8.4	(0.5)	7.0	(0.7)	2.9	(0.4)
Dysthymia	1.5	(0.1)	1.9	(0.2)	1.0	(0.1)	1.1	(0.2)	1.7	(0.3)	2.3	(0.5)	0.5	(0.2)
Bipolar I-II-sub disorders	2.8	(0.2)	2.8	(0.2)	2.9	(0.3)	4.7	(0.6)	3.5	(0.4)	2.2	(0.3)	0.7	(0.2)
Any mood disorder	9.7	(0.4)	11.6	(0.5)	7.7	(0.6)	12.9	(0.7)	11.9	(0.7)	9.4	(0.7)	3.6	(0.4)
III. Impulse-control Disorders														
Oppositional-defiant disorder[4]	1.0	(0.2)	1.1	(0.2)	0.9	(0.3)	1.2	(0.3)	0.8	(0.2)	--	--	--	--
Conduct disorder[4]	1.0	(0.2)	0.4	(0.1)	1.7	(0.5)	1.4	(0.3)	0.8	(0.3)	--	--	--	--
Attention-deficit/hyperactivity disorder[4]	4.1	(0.3)	3.9	(0.6)	4.3	(0.5)	3.9	(0.4)	4.2	(0.6)	--	--	--	--
Intermittent explosive disorder	4.1	(0.3)	3.4	(0.4)	4.8	(0.4)	8.3	(0.9)	4.6	(0.4)	2.1	(0.3)	0.9	(0.3)
Any impulse control disorder[4,6]	10.5	(0.7)	9.3	(1.0)	11.7	(0.8)	11.9	(1.1)	9.2	(0.7)	--	--	--	--
IV. Substance Disorders														
Alcohol abuse with/without dependence[2]	3.1	(0.3)	1.8	(0.3)	4.5	(0.4)	7.1	(0.7)	3.3	(0.5)	1.6	(0.3)	0.3	(0.2)
Drug abuse with/without dependence[2]	1.4	(0.2)	0.7	(0.1)	2.2	(0.3)	3.9	(0.5)	1.2	(0.3)	0.4	(0.1)	0.0	(0.0)
Nicotine dependence[2]	11.0	(0.6)	10.5	(0.8)	11.6	(0.7)	16.7	(1.4)	11.2	(1.0)	10.0	(1.1)	5.6	(0.7)
Any substance disorder[2]	13.4	(0.6)	11.6	(0.8)	15.4	(0.9)	22.0	(1.6)	13.8	(1.1)	11.2	(1.2)	5.9	(0.7)
V. Any Disorder														
Any[5]	32.4	(1.1)	34.7	(1.1)	29.9	(1.3)	43.8	(1.8)	36.9	(1.3)	31.1	(2.0)	15.5	(1.0)

[1]This table includes updated data as of July 19, 2007. Updates reflect the latest diagnostic, demographic and raw variable information.

[2]Assessed in the Part II sample (n = 5692).

[3]Assessed in a random one-third of the Part II sample (n = 2073).

[4]Assessed in the Part II sample among respondents in the age range 18-44 (n = 3197).

[5]Estimated in the Part II sample. No adjustment is made for the fact that one or more disorders in the category were not assessed for all Part II respondents.

[6]The estimated prevalence of any impulse-control disorder is larger than the sum of the individual disorders because the prevalence of intermittent explosive disorder, the only impulse-control disorder that was assessed in the total sample, is reported here for the total sample rather than for the sub-sample of respondents among whom the other impulse-control disorders were assessed (Part II respondents in the age range 18-44). The estimated prevalence of any impulse-control disorder, in comparison, is estimated in the latter sub-sample. Intermittent explosive disorder has a considerably higher estimated prevalence in this sub-sample than in the total sample.

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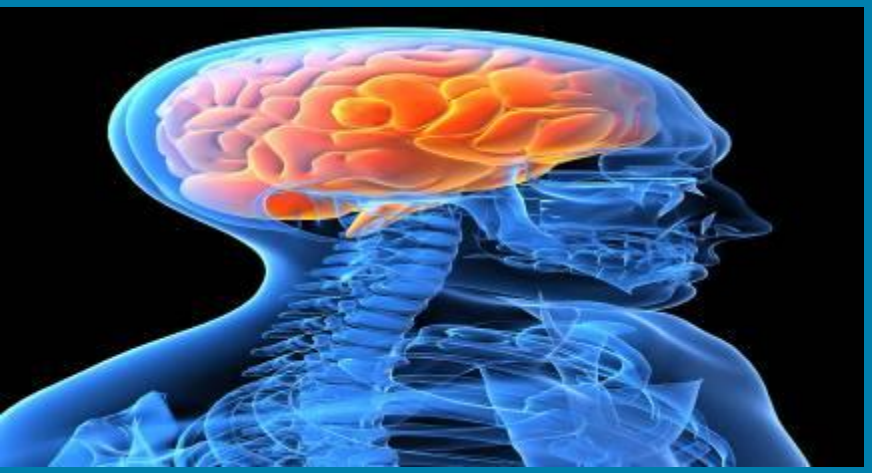
http://www.hcp.med.harvard.edu/ncs/ftpdir/table_ncsr_12monthprevgenderxage.pdf

We Call it the NECK!!!!



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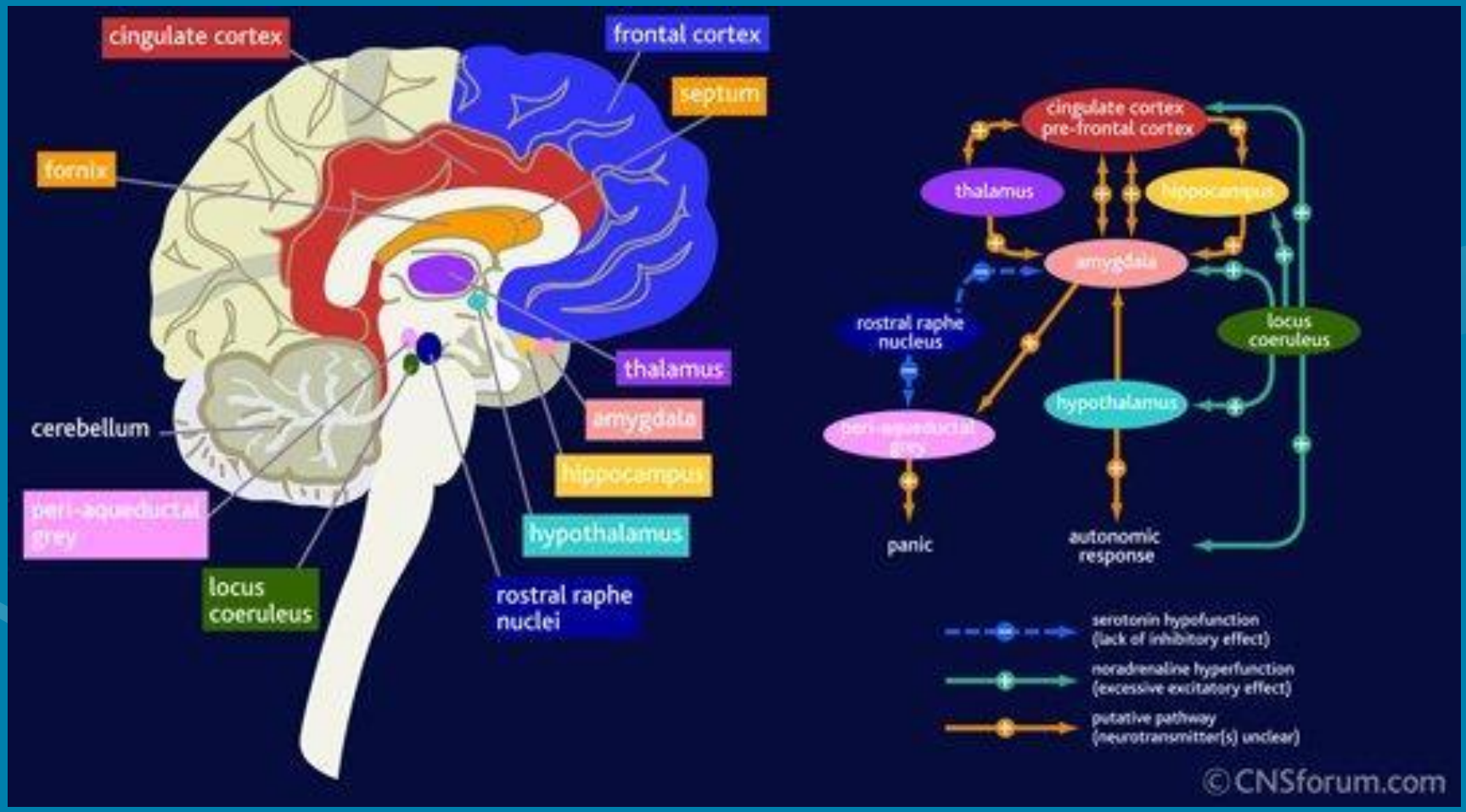
The Master of the Universe!



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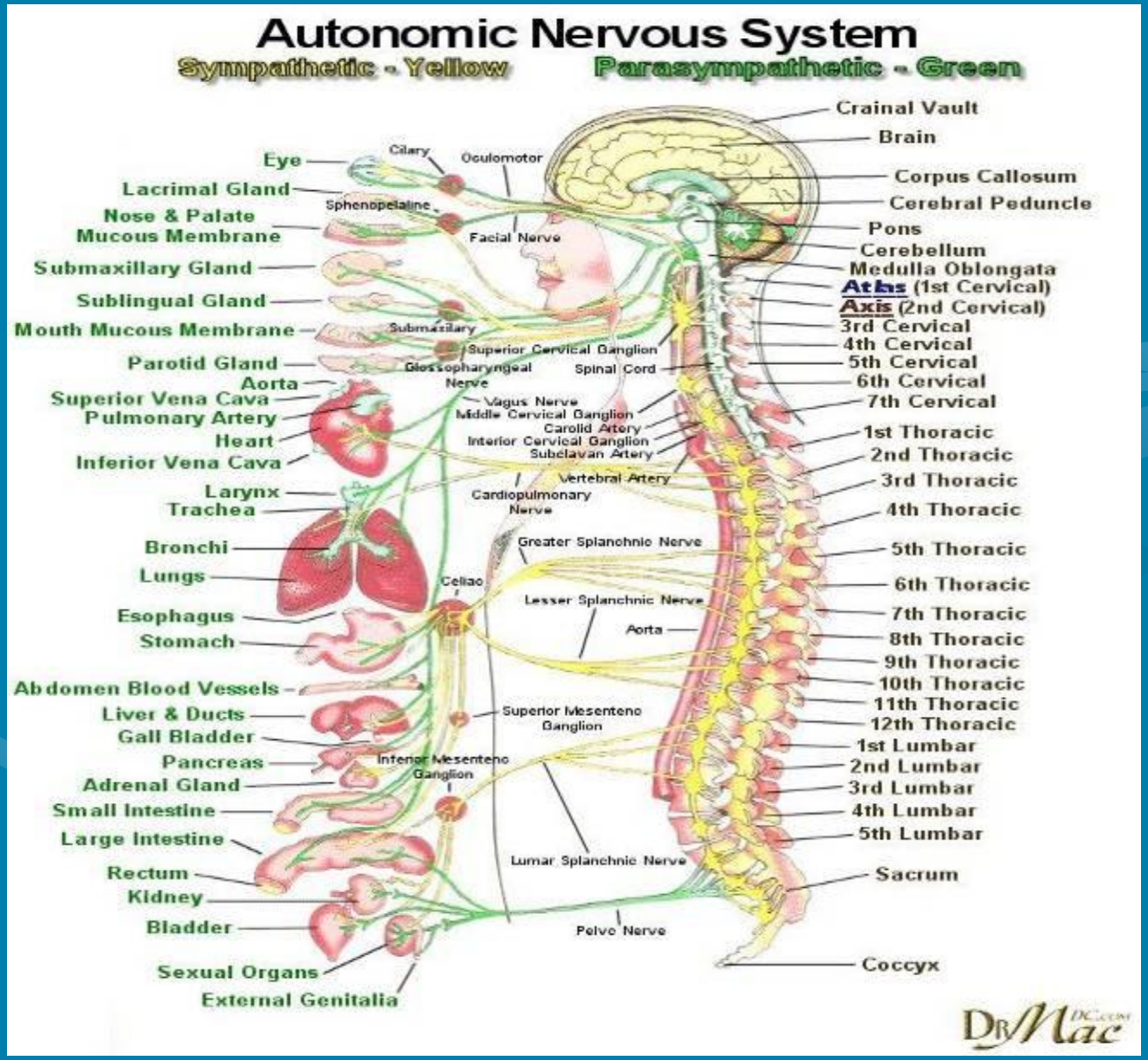
It Is All In Your Head!



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PCPs Preferred 8 to 1

- 8 times as many undiagnosed, asymptomatic adults stated more likely to see PCP than a psychiatric professional for help with a mental health issue

National Mental Health Association.America's mental health survey, May 2000. Conducted by Roper Starch Worldwide, Inc. www.roper.com/Newsroom/content/news189.htm

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Most See PCPs anyway

- 54% of people with diagnosed psychiatric conditions are treated in primary care only

Druss BG, Marcus SC, Olfson M Pincus HA. The most expensive medical conditions in America. Health Aff (Millwood). 2002 Jul-Aug;21(4):105-11.

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Most Prescriptions by PCPs

- Primary care providers write 75% of all psychotropic medication prescriptions.

Pincus, Tanielian, Marcus, Olfson, Zarin, Thompson, Zito, (1998). Prescribing trends in psychotropic medications: Primary care, psychiatry, and other medical specialties. *JAMA, 279,* 526-531.

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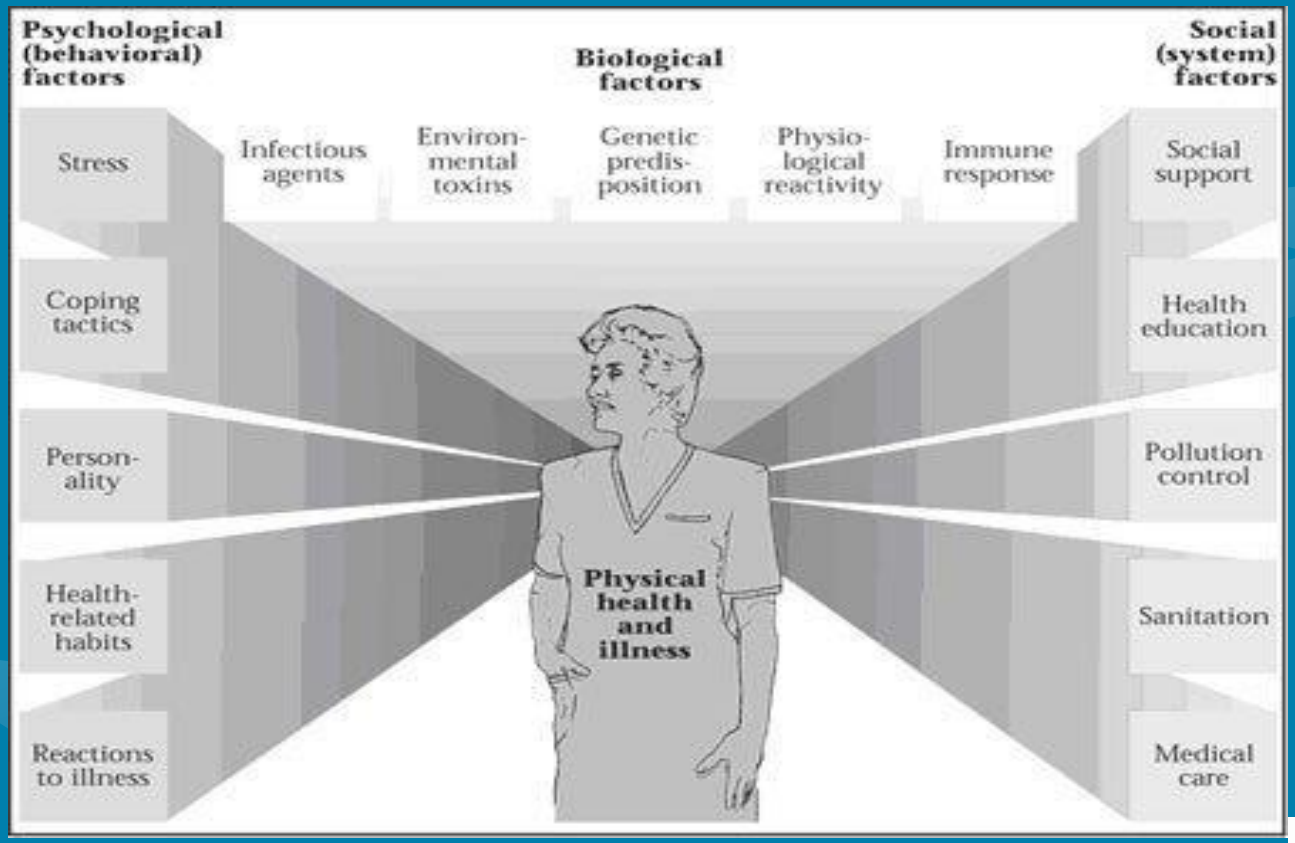
Disease is a 3 Legged Monster



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Double the Trouble
Depression and Diabetes

- Risk factor for type 2 diabetes mellitus
- Decreased adherence
- Worse control
- Increased costs
- Morbidity and Mortality Sooner

Evans DL, Charney, DS
http://www.nova-health.org/index.html

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Depression Causes Heartbreak

- Increased Depression risk with Ischemic Heart Disease
- Depression post MI > ↓ outcome
- Depression cardio-vascular risk = smoking risk
- Six-fold increase in mortality

Charles Nemeroff, MD, *PhD "Depression and Heart Disease: Link is Clear" JAMA 1993;270:1819-25*

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10 Deadly Behaviors

Tobacco use

Lack of physical activity

Avoidable infectious exposure

Gun use

Unsafe driving

Poor diet

Alcohol abuse

Exposure to toxins

Unsafe sex

Illicit drug use.

More than half - smoking, being inactive and eating badly.

Actual causes of death in the United States.
McGinnis JM - *JAMA* - 10-NOV-1993; 270(18): 2207-12

http://www.nhregister.com/articles/2008/09/22/news/b1-katzcolumn.txt

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Groundbreaking Report! Medicines Do Not Work If You Do Not Take Them

- 125,000 deaths per year
- 10% of hospital admissions
- 23% of nursing-home admissions
- 1/3 of prescriptions never filled
- 1/2 of prescriptions filled are taken incorrectly

Meta-Analysis of Trials of Interventions to Improve Medication Adherence
Andrew M. Peterson, Liza Takiya, Rebecca Finley
Posted: 04/28/2003; American Journal of Health-System Pharmacy. 2003;60(7) © 2003 American Society of Health-System Pharmacists

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Lower Income
Higher Psychiatric Problems

- Psych problems >2x more common
- Low-income frequently only have access to PCP
- Depression(23%), tobacco abuse(6.7%), anxiety(6.0%) - 3 of top 5 dx charted
- 50% ≥ 2 medical problems. 50% of these included depression, anxiety, or alcohol abuse.

Mauksch LB, Tucker SM, Katon WJ, et al: Mental illness, functional impairment, and patient preferences for collaborative care in an uninsured primary care population. Journal of Family Practice 50:41-47, 2001

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Look Under the Rock

- Estimated 50 percent of mental health problems go un-identified
- Most do have contact with PCPs
- Meet and treat people where they are

U.S. Dept. of Health and Human Services. (2001). *Report of a Surgeon General's working meeting on the integration of mental health services and primaryhealth care.* Rockville, MD: Author. www.surgeongeneral.gov/library/mentalhealthservices/mentalhealthservices.PDF4.

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Treat Mild Illness Prevent Severe Illness

If there was increased detection of early stage psychiatric illness in primary care, there would be prevention of individuals going on to more severe episodes of major psychiatric illnesses

Outcome = ⇩ Morbidity, Mortality and Money

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Treatment in Primary Care Works

- IMPACT (Evidenced Based PCP Care) intervention - 50% or greater improvement in depression at 12 months, compared to 19% in usual care
- Costs over 4y - IMPACT patients had $3300 lower average costs for all their medical care vs usual care

http://impact-uw.org/about/research.html

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TABLE 4

COMPARISON OF PRIMARY VS. PSYCHIATRIC CARE IN STAR*D

- No differences in severity of depressive illness
- Minimal differences in depressive symptom presentation
- Approximately 50% of patients had recent suicidal ideation in both
- More medical comorbidity in primary care
- More psychiatric comorbidity in primary care
- Chronic depressions more prevalent in primary care
- No differences in remission rates with optimized SSRI treatment

vs.=versus; STAR*D=Sequenced Treatment Alternatives to Relieve Depression; SSRI=selective serotonin reuptake inhibitor.

Ziffra MS, Gilmer WS. *Primary Psychiatry.* Vol 14, No 1. 2007.

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Substance Abuse Treatment in Primary Care Works

- Screening and Brief Intervention and Referral to Treatment (SBIRT)
- 536,000 people across all settings in 17 states
- 14.8% were positive
- Protocol-driven brief intervention in primary care.
- 30 positive trials

Gentilello L, Villaveces A, Ries RR et al. Detection of acute alcohol intoxication and chronic alcohol dependence by trauma center staff. J Trauma; 47:1131-9.

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Why we need primary care in psychiatry?

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The Seriously Mentally Ill (SMI) Need more whole body care

- SMI → ↑diabetes, dyslipidemia, lung disease,liver disease, hypertension, obesity cardiovascular disease, infectious disease, dental disease
- Die 25 years too early
- 70% - 1; 45% - 2; 30% - ≥ 3

Freeman, E, Yoe, J. The Poor health status of consumers of mental healthcare: Behavioral disorders and chronic disease, Presentation to NASMHPD Medical Directors Work Group,May 2006

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Desegregate Mental Health

- Outcome of Segregating Mental Health

"dead at 55"

COD = heart attack

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Stigma Kills

- In schizophrenia – no treatment for:
  - 30.2% with diabetes
  - 62.4% with hypertension
  - 88.0% with dyslipidemia

Nasrallah HA, Meyer JM, Goff DC, et al. Low rates of treatment for hypertension, dyslipidemia and diabetes in schizophrenia: data from the CATIE schizophrenia trial sample at baseline. Schizophr Res. 2006; 86: 15-22.

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Why we can not afford not to integrate?

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$653,000,000,000

- Non-adherence = $100 billion
- Depression = $83 Billion
- Nicotine = $193 Billion
- Alcohol = $185 Billion
- Obesity = $92 Billion

Meta-Analysis of Trials of Interventions to Improve Medication Adherence
Peterson, Liza Takiya, Rebecca Finley Posted: 04/28/2003; American Journal of Health-System Pharmacy. 2003;60(7) © 2003 American Society of Health-System Pharmacists
http://www *J Clin Psychiatry* 2003; 64: 1465-1475
http://www.cdc.gov/tobacco/data_statistics/fact_sheets/economics/econ_facts/index.htm
http://pubs.niaaa.nih.gov/publications/economic-2000/alcoholcost.PDF
cdc.gov/obesity/causes/economics.html

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Behaviors Kill 50%

- Tobacco (435 000 deaths; 18.1% of total US deaths)
- Poor diet and inactivity (400 000 deaths; 16.6%)
- Alcohol (85 000 deaths; 3.5%)
- Microbial agents (75 000)
- Toxins(55 000)
- MVA (43 000)
- Firearms (29 000)
- Sexual (20 000)
- Drugs (17 000).

Actual Causes of Death in the United States, 2000
Ali H. Mokdad, PhD; James S. Marks, MD, MPH; Donna F. Stroup, PhD, MSc; Julie L. Gerberding, MD, MPH
JAMA. 2004;291:1238-1245.

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Working is Healthy

- Psychiatric conditions are the leading cause of disability in the US and Canada for ages 15-44

http://www.nimh.nih.gov/health/topics/statistics/index.shtml

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Not Working is Costly

- Mood disorders are the:

7th most costly

2nd most disabling

Druss BG, Marcus SC, Olfson M Pincus HA. The most expensive medical conditions in America. Health Aff (Millwood). 2002 Jul-Aug;21(4):105-11.

http://www.nimh.nih.gov/health/topics/statistics/index.shtml

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Depression Plus DM or CHF

- 1y costs with $22,960, $11,956 without.
- Depressed spent significantly more in nearly every health care cost category except specialty mental health care.
- Mental health care costs - less than 1 %

Unützer J, Schoenbaum M, Katon W, Fan M, Pincus H, Hogan D, Taylor J. Health care costs associated with depression in medically ill fee-for-service Medicare participants. *Journal of the American Geriatric Society*. Published online ahead of print Jan. 16, 2009.

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What is Psychiatry Integrated Primary Care?

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Family Doctor's Perspective

"To provide holistic care, we must always strive to meet patients where they are physically, emotionally and spiritually. The integration of primary medical and psychiatry services is a constant reminder to be conscious of all areas since no one area can be fully addressed in isolation of the others."

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Different Levels of Integration

Levels of Integration

	Level of Integration	Attributes
Minimal Collaboration	I	Separate site & systems Minimal communication
Basic Collaboration from a distance	II	Active referral linkages Some regular communication
Basic Collaboration on site	III	Shared site; separate systems Regular communication
Collaborative Care partly integrated	IV	Shared site; some shared systems Coordinated treatment plans Regular communication
Fully Integrated System	V	Shared site, vision, systems Shared treatment plans Regular team meetings

Modified from Doherty, McDaniel, and Baird - 1996

Doherty WJ, **McDaniel SH**, **Baird MA**. Five levels of primary care/behavioral healthcare collaboration. Behav Healthc Tomorrow. 1996 Oct;5(5):25-7

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PCHC PIPC History

- Began Integration over 10 years ago by placing a PCHC employed counselor in the primary care clinic with partially integrated care using a shared site but different medical record

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Level 3 Failed

- In 2003 added an on-site, part-time psychiatric nurse practitioner through contract with an area community mental health agency with separate systems
- 2 separate systems (level 3) proved too expensive for survival

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Level 5 Success

- In 2004 PCHC decided to start level 5 psychiatry integrated primary care
- PCHC hired a psychiatrist as the first step and added multi-disciplinary providers to keep up with the demand at a financially responsible pace

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Goals

- Meet the primary care needs
- De-fragment and De-stigmatize care
- Allow collaboration in the moment
- Reduce psychological and social barriers
- Cut costs of chronic disease care
- Promote cross-education
- Be financially viable

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5 Years - 800 % Growth

- September 2004, 1 Psychiatrist & 1 MH/SA Counselor
- September 2009 17.25 FTE Billable Providers in 8 clinics

5 Psychiatric Nurse Practitioners – 5 FTE
4 MDs – Psychiatrists -1.85 FTE
3 Psychologists - 1.5 FTE
4 Licensed Clinical Professional Counselors – 3.8 FTE
3 Licensed Clinical Social Workers – 2.5 FTE
3 APRN– Clinical Nurse Specialists – 2.6 FTE

Penobscot Community Health Care

Started Now in 8 Clinics

- Have started psychiatry integrated primary care model now in 8 clinics within our multiple clinic system
- Takes 1-2 years to mature and "feel the same"

Penobscot Community Health Care

Where Do I start?

- Start with psychiatrist, psychiatric nurse practitioner or psychotherapist as dictated by the primary care practice's own evaluation of their needs based on their population and strengths
- Most choose Psychiatric NP - can prescribe and do counseling.

Penobscot Community Health Care

Next

- Pattern has been to then add a Psychologist, LCSW or LCPC within 1 year after the Psychiatric NP starts
- Psychiatric professionals in integrated settings should be comfortable with treatments for all psychiatric conditions including substance abuse
- Works as well if start with Psychologist, LCSW or LCPC and then add a psychiatric prescriber as needed.

Penobscot Community Health Care

Psychiatric Medication Management
Psychiatric Evaluations/Consultations

- Psychiatric nurse practitioner

Holistic nursing fits well with primary care team culture

Less expensive

Hard to find

- Psychiatrist

More depth of training – 4 years additional training.

More expensive – 75% more

A little harder to find

Penobscot Community Health Care

Qualities needed

- Experienced
- Independent Thinker
- Flexible
- Confident
- Experience on a health team
- Non-judgmental
- Good Communicator
- Motivated to build something more than individual practice.
- Not hyper-sensitive
- Not expecting everyone else to change for them

Penobscot Community Health Care

Great time to be a Psych NP

- Psychiatric Nurse Practitioner

Hard to find so plan for long recruitment period

Pay 83-100K. More experience is worth more money in revenue and best clinically

Choose someone who can become the leader of the psychiatric team as it grows

Need at least 2 years experience to be independent

Recommend an arrangement with a psychiatrist to consult formally or informally and supervise - 2-4h/month - $400 – 800. with typical primary care population and increased from there with higher severity populations

Penobscot Community Health Care

One system, One Site, One Vision, One Mission, One Budget

- Psychiatric providers are part of the primary care team
- Evaluation feedback is gotten from all
- No separate designations, no separate signs
- Chief of Psychiatry and the Primary Care Medical Director report to the Executive Medical Director.

Penobscot Community Health Care


Penobscot Community Health Center


Penobscot Community Health Care
Summer Street Community Clinic


Penobscot Pediatrics

I Can Not Tell the PCPs Apart From the Shrinks!

- Co – located with offices in the primary care mix
- Part of the primary care team, helped by same staff, go to same meetings, have the same practice manager, under the same budget, chart in the same record, follow same policies and procedures

Penobscot Community Health Care

Penobscot Community Health Care

We are Family

- Attends clinical meetings with family practice practitioners as a member of the "family"
- Same practice manager, and clinical coordinator
- All providers on same email list

Penobscot Community Health Care

Curbsides

- Helps patients in the moment
- Cross-educates
- Multiplies the exchange across matching cases
- Assimilates the psychiatric professional
- Develops the "I have your back" team attitude
- Interruptions are OK

Penobscot Community Health Care

Greasing the Wheel

- Pop-ins used to reduce fear of "shrinks"
- Non-same day referrals made via EMR
- Complicated referrals followed up with a provider to provider communication
- Same-day consults
- Same-day urgent referrals

Penobscot Community Health Care

Population Risk Stratification and Management

Health Behavior and Screening Assessments

Untreated chronic psychiatric disorders have a significant negative effect on other chronic disease management, health risk, and social risk

Psychosocial roadblocks like transportation, lost job, few natural supports and no insurance which also have a significant negative effect on chronic disease management, health risk, and social risk

30 minute visit before initial PCP

Billable provider – LCSW/LCPC

Penobscot Community Health Care

SSC Health screen: Oscar T Grouch

Intake Review

- [x] Patient Bill of Rights reviewed and questions answered
- [x] HIPPA reviewed and questions answered
- [x] PCHC services reviewed and questions answered
- [x] SF12 Health Profile completed and scored

Literacy Level: HS

Depression

Have you often been bothered by feeling down, depressed or hopeless? No

Have you often been bothered by little interest or pleasure in doing things? No

Comments:

Alcohol Use Disorder

When was the last time you had more than five drinks in one day?

- (•) Never
- ( ) In the past three months
- ( ) Over three months ago.

Comment:

Intimate Partner Violence

Have you been hit, kicked, punched, or otherwise hurt by someone in the past year? No

Do you feel safe in your current relationship? No

Is there a partner from a previous relationship who is making you feel unsafe now? No

Comments:

Social Anxiety Disorder

Fear of embarrassment causes me to avoid doing things or speaking to people: Not at all

I avoid activities in which I am the center of attention: Extremely

Being embarrassed or looking stupid are among my worst fears: Not at all

Comments:

Generalized Anxiety Disorder

Over the last 2 weeks, how often have you been bothered by the following problems?

Feeling nervous, anxious, or on edge: Not at all

Not being able to stop or control anything: Not at all

Comments:

Prev Form (Ctrl+PgUp) | Next Form (Ctrl+PgDn) | Close

Penobscot Community Health Care

SSC Health screen: Oscar T Grouch

When was the last time you had more than five drinks in one day?
- (•) Never
- ( ) In the past three months
- ( ) Over three months ago.

Comment:

Intimate Partner Violence

Have you been hit, kicked, punched, or otherwise hurt by someone in the past year? No

Do you feel safe in your current relationship? No

Is there a partner from a previous relationship who is making you feel unsafe now? No

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I avoid activities in which I am the center of attention: Extremely

Being embarrassed or looking stupid are among my worst fears: Not at all

Comments:

Generalized Anxiety Disorder

Over the last 2 weeks, how often have you been bothered by the following problems?

Feeling nervous, anxious, or on edge: Not at all

Not being able to stop or control anything: Not at all

Comments:

PTSD

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

Have had nightmares about it or thought about it when you did not want to? No

Tried hard not to think about it or went out of your way to avoid situations that reminded you of it? No

Were constantly on guard, watchful, or easily startled? No

Felt numb or detached from others, activities, or your surroundings? No

Comments:

Prev Form (Ctrl+PgUp) | Next Form (Ctrl+PgDn) | Close

Penobscot Community Health Care

Population Risk Stratification and Management

Health Behavior and Screening Assessments

If mini-screen positive for:

Depression – PCP evaluates using PHQ 9, screens for evidence of Bipolar disease, screens for general medical causes of depressive symptoms and treats as usual

Penobscot Community Health Care

Population Risk Stratification and Management

Health Behavior and Screening Assessments

If mini-screen positive for:

Generalized Anxiety Disorder – PCP evaluates further – screens for general medical causes of GAD symptoms and treats as usual

Penobscot Community Health Care

Population Risk Stratification and Management

Health Behavior and Screening Assessments

If mini-screen positive for:

Alcohol Use Disorder – PCP evaluates further – screens for damage from alcohol and educates regarding, assesses alcohol withdrawal risk, discusses alcohol deterrent medications and offers referral to counseling

Penobscot Community Health Care

Population Risk Stratification and Management

Health Behavior and Screening Assessments

If mini-screen positive for:

Social Anxiety Disorder – referral made to Counselor for more complete evaluation of social phobia and treats as usual

Population Risk Stratification and Management

Health Behavior and Screening Assessments

If mini-screen positive for:

Domestic Violence – counselor offers immediate safe resources and counseling

Penobscot Community Health Care

Population Risk Stratification and Management

Health Behavior and Screening Assessments

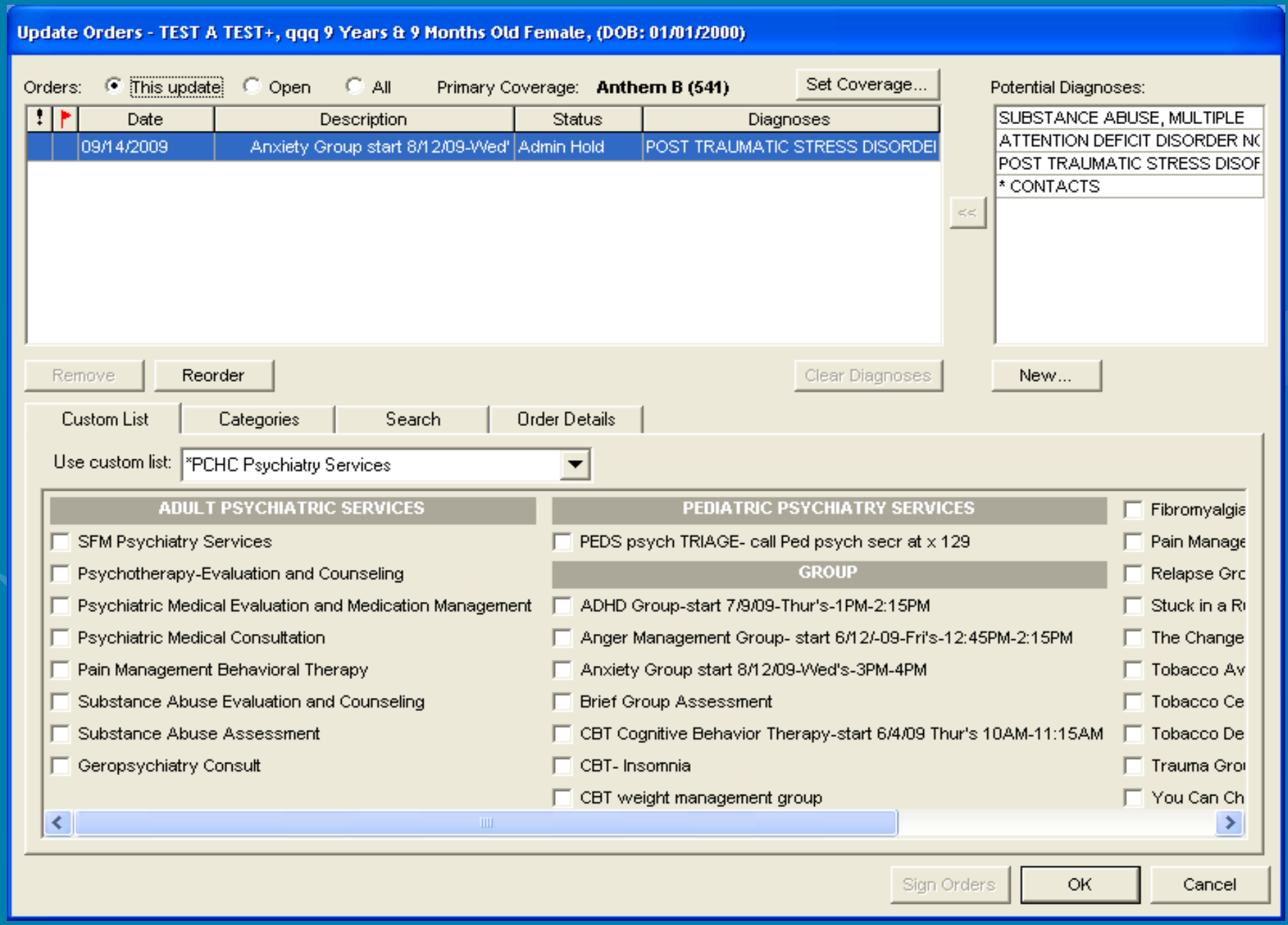
Practice can individualize the assessments to meet their needs and resources

Penobscot Community Health Care

Referral

- PCP orders for a Psychiatric Assessment, Counseling, Group
- Electronically routed to the medical secretary who sets up the appointment

Penobscot Community Health Care


Update Orders - TEST A TEST+, qqq 9 Years & 9 Months Old Female, (DOB: 01/01/2000)
Orders:
This update
Open
All
Primary Coverage:
Anthem B (541)
Set Coverage...
Potential Diagnoses:
Date
Description
Status
Diagnoses
09/14/2009
Anxiety Group start 8/12/09-Wed'
Admin Hold
POST TRAUMATIC STRESS DISORDEI
SUBSTANCE ABUSE, MULTIPLE
ATTENTION DEFICIT DISORDER NC
POST TRAUMATIC STRESS DISOF
* CONTACTS
<<
Remove
Reorder
Clear Diagnoses
New...
Custom List
Categories
Search
Order Details
Use custom list:
*PCHC Psychiatry Services
ADULT PSYCHIATRIC SERVICES
SFM Psychiatry Services
Psychotherapy-Evaluation and Counseling
Psychiatric Medical Evaluation and Medication Management
Psychiatric Medical Consultation
Pain Management Behavioral Therapy
Substance Abuse Evaluation and Counseling
Substance Abuse Assessment
Geropsychiatry Consult
PEDIATRIC PSYCHIATRY SERVICES
PEDS psych TRIAGE- call Ped psych secr at x 129
GROUP
ADHD Group-start 7/9/09-Thur's-1PM-2:15PM
Anger Management Group- start 6/12/-09-Fri's-12:45PM-2:15PM
Anxiety Group start 8/12/09-Wed's-3PM-4PM
Brief Group Assessment
CBT Cognitive Behavior Therapy-start 6/4/09 Thur's 10AM-11:15AM
CBT- Insomnia
CBT weight management group
Fibromyalgia
Pain Manage
Relapse Gro
Stuck in a R
The Change
Tobacco Av
Tobacco Ce
Tobacco De
Trauma Grou
You Can Ch
Sign Orders
OK
Cancel

Have Same Support Needs

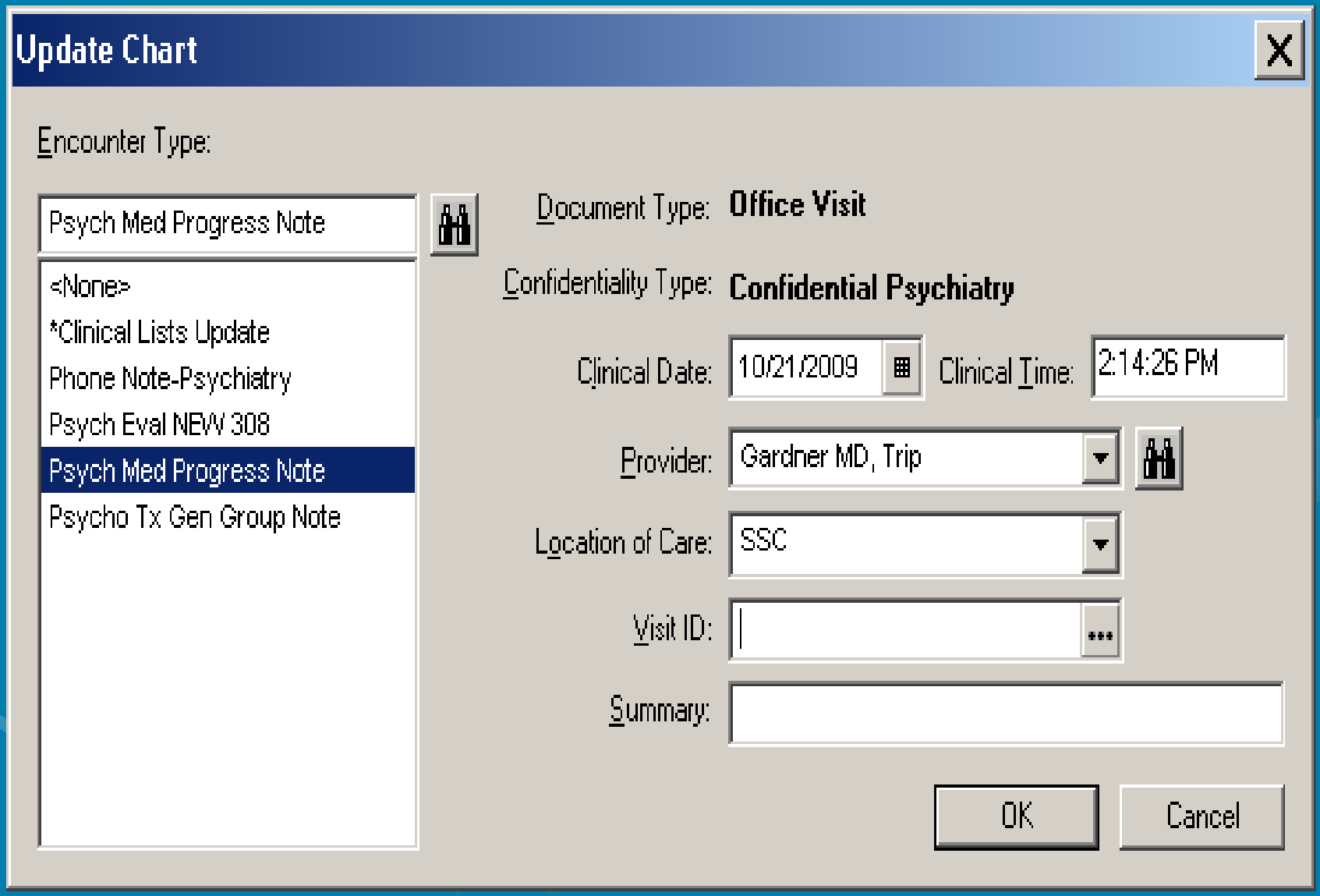
- 0.45 FTE medical secretary per psychiatric medication prescriber
- 0.30 FTE medical secretary per counselor
- 0.25 FTE medical assistant per psychiatric medication provide for vital signs, narcotics contract, pill counts, labs, triage all clinical calls, call in med refills

Penobscot Community Health Care

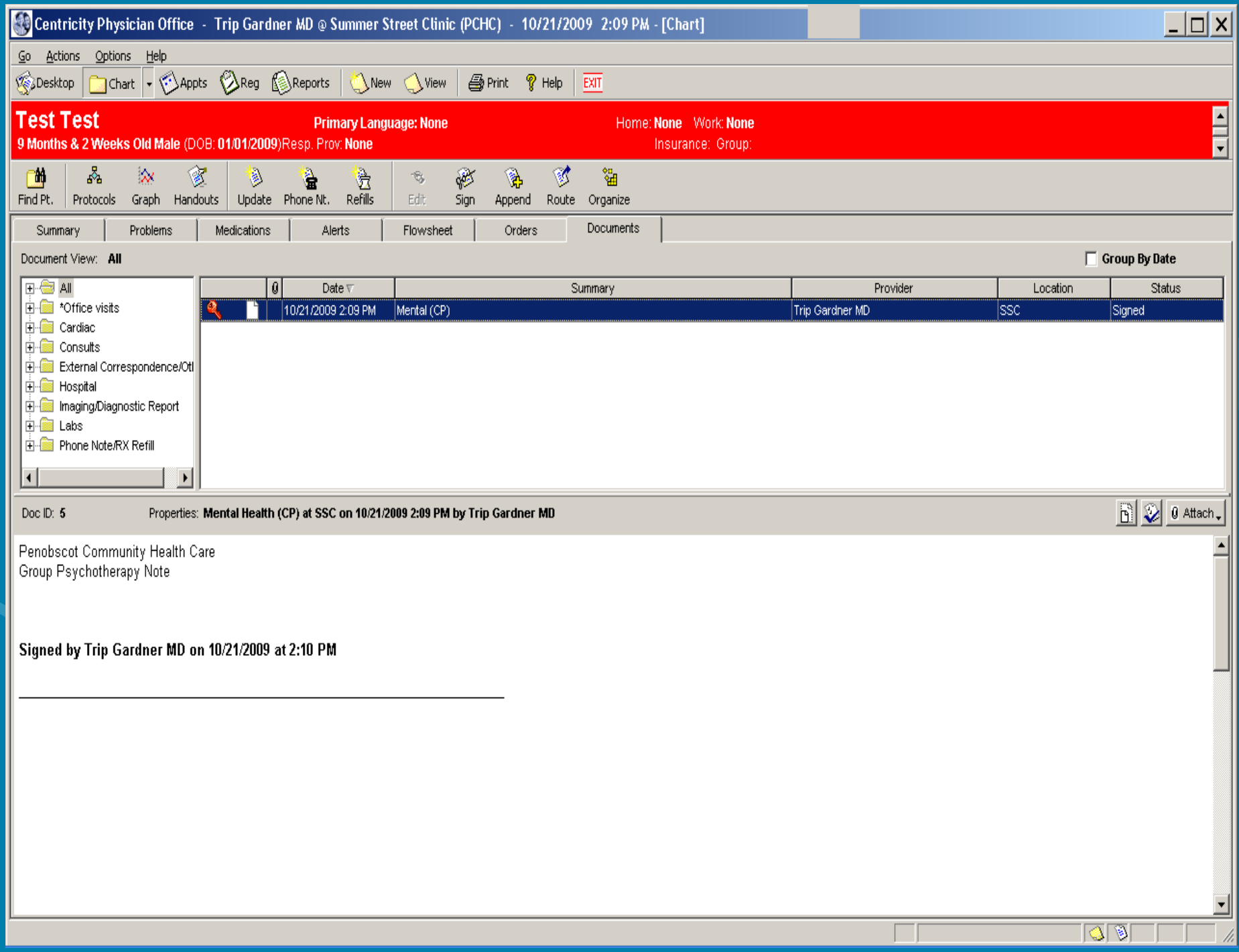
Same Language

- EMR Templates for all notes
- Psychiatric medical record is kept sequentially with the rest of the medical record
- Special electronic key offers extra protection as only providers have access
- Looks like other health records

Penobscot Community Health Care



Penobscot Community Health Care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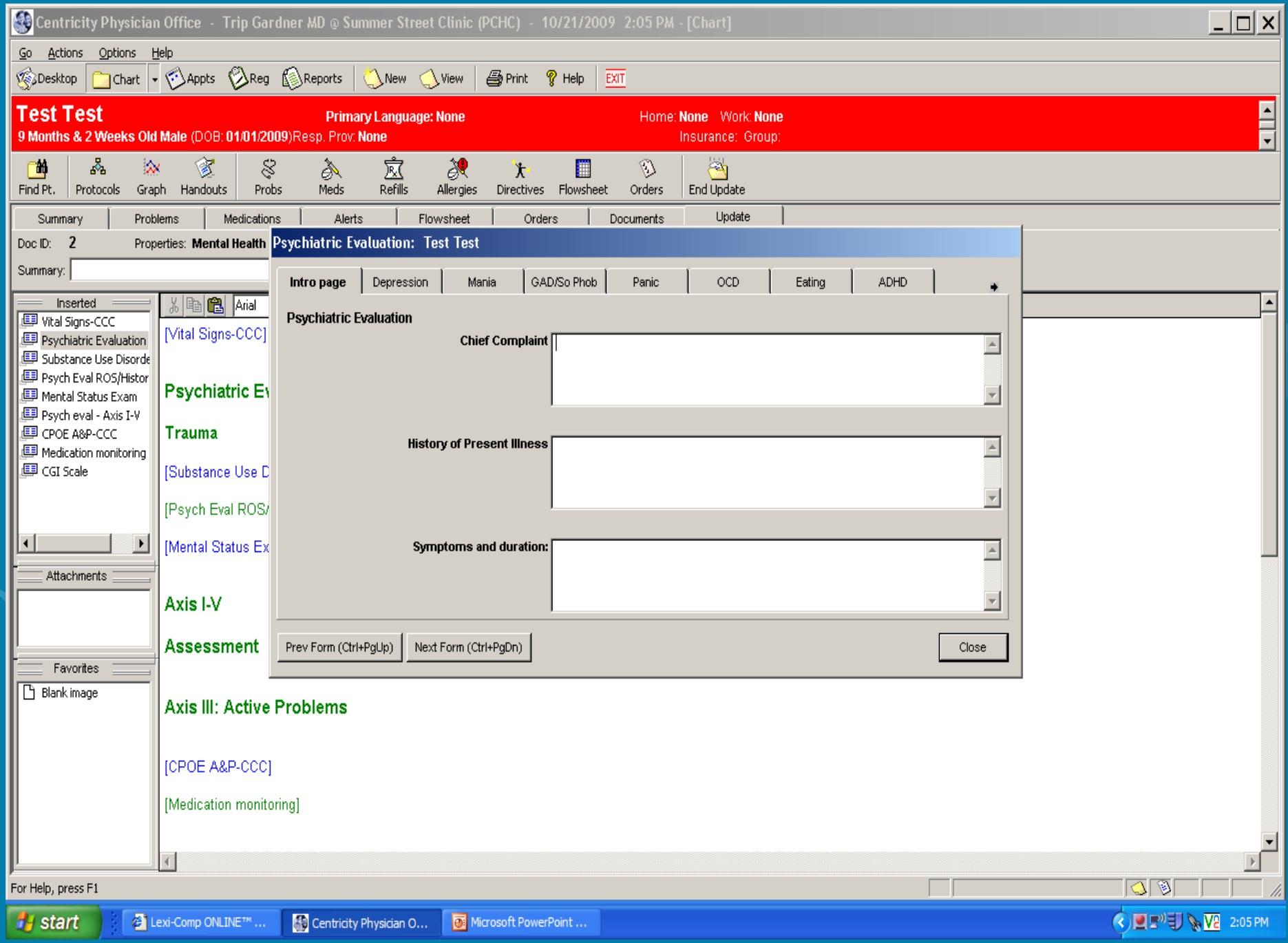
Go Actions Options Help
Desktop Chart Appts Reg Reports New View Print Help EXIT
Test Test
Primary Language: None
Home: None Work: None
9 Months & 2 Weeks Old Male (DOB: 01/01/2009) Resp. Prov: None
Insurance: Group:
Find Pt. Protocols Graph Handouts Update Phone Nt. Refills Edit Sign Append Route Organize
Summary Problems Medications Alerts Flowsheet Orders Documents
Document View: All
Group By Date
All
*Office visits
Cardiac
Consults
External Correspondence/Otl
Hospital
Imaging/Diagnostic Report
Labs
Phone Note/RX Refill
Date
Summary
Provider
Location
Status
10/21/2009 2:09 PM
Mental (CP)
Trip Gardner MD
SSC
Signed
Doc ID: 5
Properties: Mental Health (CP) at SSC on 10/21/2009 2:09 PM by Trip Gardner MD
Attach
Penobscot Community Health Care
Group Psychotherapy Note
Signed by Trip Gardner MD on 10/21/2009 at 2:10 PM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Test Test
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9 Months & 2 Weeks Old Male (DOB: 01/01/2009) Resp. Prov: None
Insurance: Group:
Find Pt. Protocols Graph Handouts Probs Meds Refills Allergies Directives Flowsheet Orders End Update
Summary Problems Medications Alerts Flowsheet Orders Documents Update
Doc ID: 2
Properties: Mental Health
Summary:
Inserted
Vital Signs-CCC
Psychiatric Evaluation
Substance Use Disorde
Psych Eval ROS/Histor
Mental Status Exam
Psych eval - Axis I-V
CPOE A&P-CCC
Medication monitoring
CGI Scale
Attachments
Favorites
Blank image
Arial
[Vital Signs-CCC]
Psychiatric Ev
Trauma
[Substance Use D
[Psych Eval ROS/
[Mental Status Ex
Axis I-V
Assessment
Axis III: Active Problems
[CPOE A&P-CCC]
[Medication monitoring]
Psychiatric Evaluation: Test Test
Intro page Depression Mania GAD/So Phob Panic OCD Eating ADHD
Psychiatric Evaluation
Chief Complaint
History of Present Illness
Symptoms and duration:
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Close
For Help, press F1
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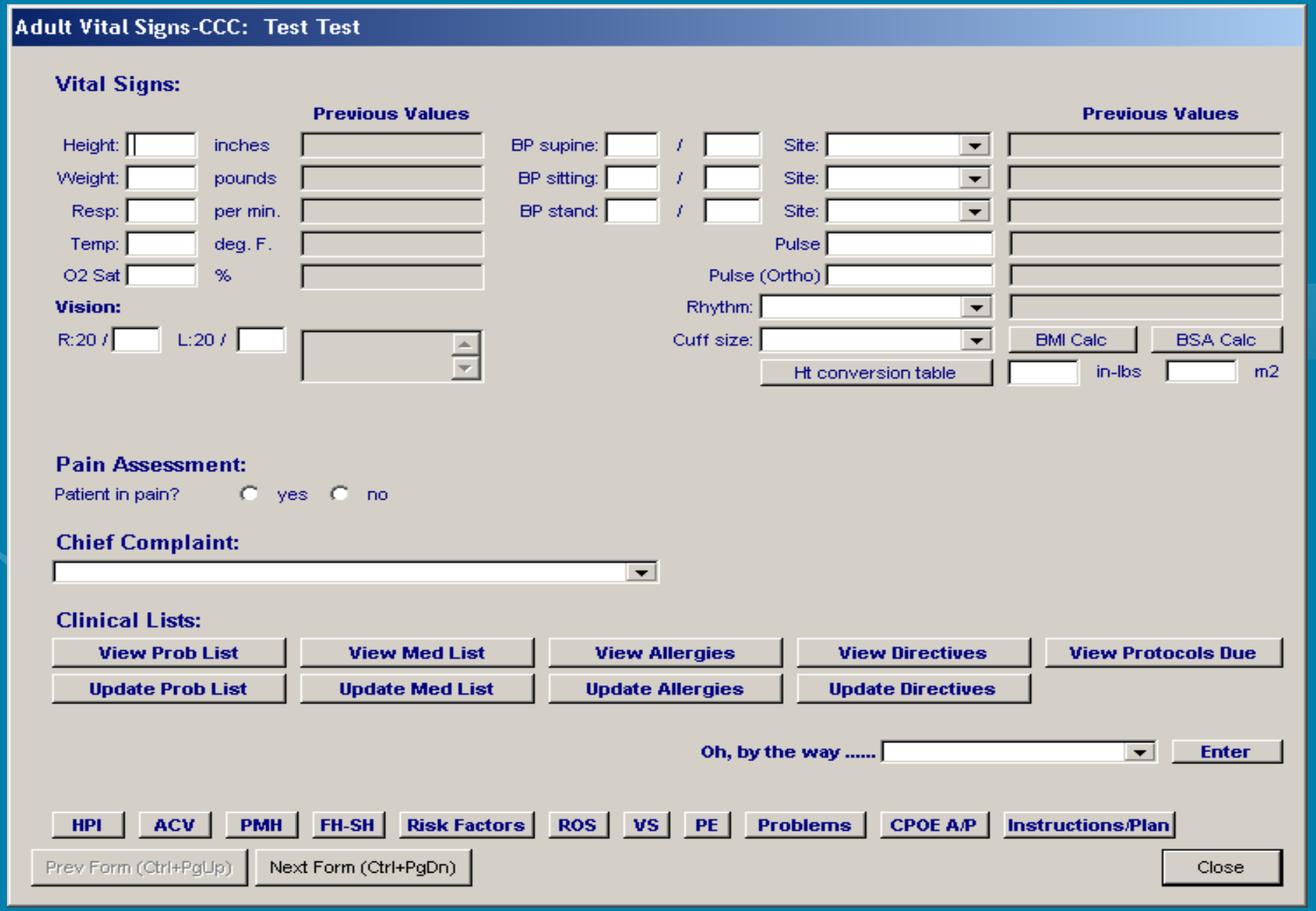
Centricity Physician O...
Microsoft PowerPoint ...
2:05 PM


Adult Vital Signs-CCC: Test Test
Vital Signs:
Previous Values
Height: inches
Weight: pounds
Resp: per min.
Temp: deg. F.
O2 Sat %
Vision:
R:20 / L:20 /
BP supine: / Site:
BP sitting: / Site:
BP stand: / Site:
Pulse
Pulse (Ortho)
Rhythm:
Cuff size:
BMI Calc
BSA Calc
Ht conversion table
in-lbs
m2
Pain Assessment:
Patient in pain? yes no
Chief Complaint:
Clinical Lists:
View Prob List
View Med List
View Allergies
View Directives
View Protocols Due
Update Prob List
Update Med List
Update Allergies
Update Directives
Oh, by the way .....
Enter
HPI
ACV
PMH
FH-SH
Risk Factors
ROS
VS
PE
Problems
CPOE A/P
Instructions/Plan
Prev Form (Ctrl+PgUp)
Next Form (Ctrl+PgDn)
Close

Psychiatric Med Test 022406: Test Test

Psychiatric Med Eval Progress | Assessment and Plan

Psychiatric Medication Evaluation Progress

Subjective: Date:

Mood is:

- [ ] Denies: racing thoughts; increased activity; impulsivity; risky judgements; pressur
- [ ] Reports racing thoughts
- [ ] Denies racing thoughts
- [ ] Reports increased activity
- [ ] Denies increased activity
- [ ] Reports impulsivity
- [ ] Denies impulsivity
- [ ] Reports risky judgements
- [ ] Denies risky judgements
- [ ] Reports pressure to keep talking
- [ ] Denies pressure to keep talking
- [ ] Reports decreased need for sleep
- [ ] Denies decreased need for sleep
- [ ] Reports grandiosity
- [ ] Denies grandiosity
- [ ] Reports distractibility
- [ ] Denies distractibility

Anxiety is

Sleep is

- [ ] with difficulty falling asleep

Prev Form (Ctrl+PgUp) | Next Form (Ctrl+PgDn) | Close

Individual Psychot Progress Nt: Test Test

Date

Session Information

Length of Session

Type of Service

Target Symptoms

Skills that are taught and/or that client is able to verbalize

Assessment: (Client's response to treatment, complexity or severity of illness)

Plan

Prev Form (Ctrl+PgUp) | Next Form (Ctrl+PgDn) | Close

Penobscot Community Health Care

Gen Group Psychot Note: Test Test

Penobscot Community Health Care

Group Psychotherapy Note

Site

Date

Length of Group

Number in Group

Group Topic

Skills taught to produce therapeutic change

Patient's response to interventions

Assessment

Plan

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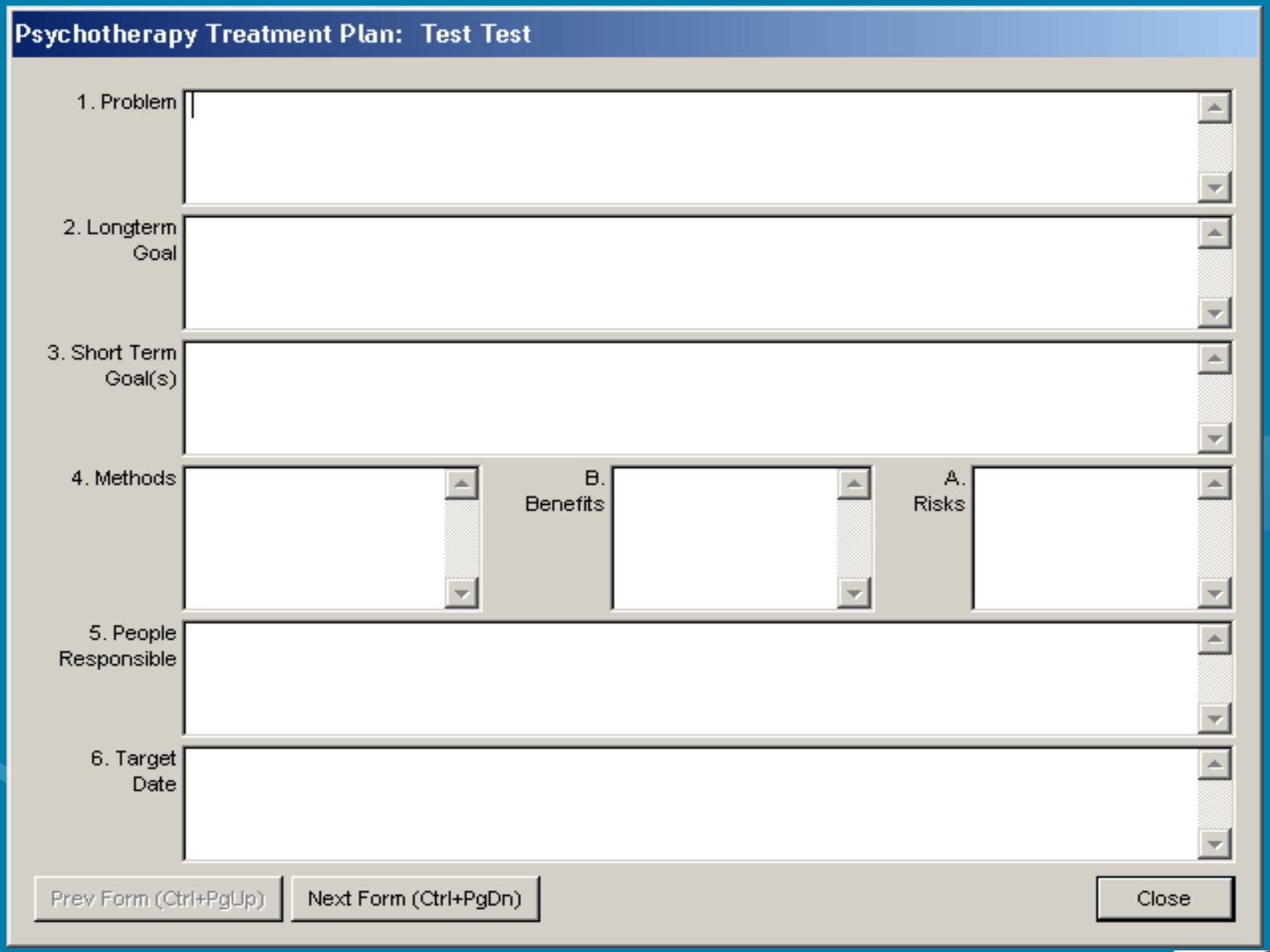
Penobscot Community Health Care



Penobscot Community Health Care

Record

- EMR
  - Print scripts
  - Print instruction for patients
  - Print education for patients
  - Medication reconciliation
  - Hand out for medication side effects
  - Allows for multiple members of the team to easily collaborate in the service of the patient

Penobscot Community Health Care

Medication monitoring tool

- For use when medications with a high potential for inappropriate use are prescribed
- Contract signed
- Last UDS
- Last pill count
- Same for all – psychiatry and primary care

Penobscot Community Health Care

Medication monitoring: TEST A TEST+, qqq

Chief complaint

Narcotic/Stimulant Workup Comments

Pain Rating	0	1	2	3	4	5	6	7	8	9	10
Best Pain	○	○	○	○	○	○	○	○	○	○	○
Worst Pain	○	○	○	○	○	○	○	○	○	○	○
Current Pain	○	○	○	○	○	○	○	○	○	○	○

Titration plan

Compliance issue

UDS

Narcotic Pill Count

Narcotic Contract date:

OSA Review

ADHD Group ○ Yes ○ No

May refill to next appt ASAP ○ Yes ○ No

Comments

Risk rating

Rating Scale

ex. 1= Cancer Pain 5 = Normal 10= No narcotics

Stimulant Pill Count

Stimulant Contract Date

No Refill After this Date

7 d | 14 d | 21 d | 28 d | 2 M

Prev Form (Ctrl+PgUp) | Next Form (Ctrl+PgDn) | Close

Roadblocks

- Small barriers being made into huge roadblocks; Assumptions winning over facts
- Compensation plans that lead to people thinking consciously or unconsciously that they do not have time to screen, treat and collaborate about messy psychiatric conditions
- Separate Locations – even one door
- Separate Records
- FQHC Medicare – will not pay for group psychotherapy, does not have parity yet for mental health,will not pay for LCPCs

Penobscot Community Health Care

Roadblocks

- Mental health professionals unwilling to assimilate into the primary care culture
- Mental health professionals that think the current mental health system works well
- Mental Health professionals that fail to understand that the medical model is taught to be a biopsychosocial model
- Mental Health professionals that believe that office furnishings are an important part of their therapeutic skills

Penobscot Community Health Care

Roadblocks

- Primary care practitioners that prefer to keep the psychiatric medical care separate from all the other medical care
- Primary Care practitioners that follow the **BIO**psychosocial Medical Model not the Integrated **BioPsychoSocial** Model of Healthcare
- Primary care practitioners that "don't believe in psychiatry"
- Primary care practitioners that are hesitant to consult with non-physicians

Penobscot Community Health Care

Family Doctor's Perspective

"The interface between providers in our office encourages a free flow of information and feedback which allows us to be more immediately responsive to patients' needs, provides a supportive environment for patients which reinforces treatment, and promotes true health and wellness"

Penobscot Community Health Care

Will it work financially?

Penobscot Community Health Care

Making It in the Real World

- Financially viable on its own in a FQHC
- Psychiatric Nurse Practitioners met budget goal of 8.5/d seeing on average 8.69
- Psychiatric counselors were slightly below budget goal of 7/d coming in at 6.2

Penobscot Community Health Care

Payor Mix

Site	MaineCare	Medicare	Commercial	Affordable Care (self)
Union St Psychiatry	41.99%	30.04%	15.69%	12.28%
Summer Street Community Clinic (Homeless)	46.10%	26.10%	2.98%	24.83%
Total PCHC	31.51%	28.85%	33.51.%	6.14%

Penobscot Community Health Care

No Financial Secrets

- Team oriented, solution focused
- Creative – Yes we can make it work clinically and financially attitude.
- Goals are set for individual professional types
- Financial communication is open, collaborative and honest
- Everyone knows the goal is breaking even and everyone has to pull together to be on the team

Penobscot Community Health Care

Numbers per day

- 30 minute medication (illness) management
- 90 minute psychiatric evaluation
- Groups 60 – 90 minutes
- 30 – 90 minute consultations
- 30 – 60 minute counseling sessions
- 60 minute psychosocial evaluations
- 30 minute health and behavior assessments
- 30 minute focused behavioral consultations

Penobscot Community Health Care

No Show/Same Day Cancel

- 10-20% for medication management appointments
- 20-25% for non-medication management appointments
- Start group with 2 x number wanted
- Aggressive office staff to keep slots filled

Penobscot Community Health Care

Bottom Line – Psych NP

- Psychiatric Nurse Practitioner – 91,500 salary plus 19% benefits = $108,885
- 0.25 MA – 28,350 salary plus 19% benefits = 33,737 x .25 = $8,434
- 0.45 Med receptionist/secretary – 25, 648 salary plus 19% benefits = 30,521 x .45 = $13,734
- Psychiatrist for consultation/supervision = $4800 per year
- Other expenses = $30,000
- Total = $165,853

Penobscot Community Health Care

Bottom Line – Psych NP

- 165,853 /$93 average per encounter = 1783 encounters per year
- 1783 encounters/ 45 weeks /5d per week = 8 encounters per day to break even with a psychiatric nurse practitioner at an FQHC with similar mix of payments

Penobscot Community Health Care

Bottom Line - Counselor

- Counselor (LCSW/CNS) – 60,000 salary plus 19% benefits = $71,400
- 0.30 Med receptionist/secretary – 25, 648 salary plus 19% benefits = 30,521 x .45 = $9156.3
- Other expenses = $20,000
- Total = $100556.30

Penobscot Community Health Care

Bottom Line -Counselor

- $100556.30 per year /$93 average per encounter = 1081 encounters/year
- 1081 encounters/ 45 weeks /5d per week = 5 encounters per day to break even with a counselor

Penobscot Community Health Care

How much time do we need?

Penobscot Community Health Center

- 25,444 Psychiatric per 139,828 PCP Encounters
- 15.3 % of all Encounters in Primary Care Clinic are Psychiatric Encounters
- 5.5 PCP encounter to 1 Psychiatric Encounters
- Range in all clinics o.4:1 to 16:1

Penobscot Community Health Care

How much time do we need?

- Union St Family Practice – more low income, uninsured, affordable care plan, underinsured, MaineCare

3.7 PCP encounter to 1.0 Psych NP encounter

7.1 PCP encounter to 1 counseling encounter

2.4 PCP encounter to 1 Total Psychiatric Encounter

Higher as you would expect in a population more than 2x as likely to have psychiatric conditions

Penobscot Community Health Care

How much time do we need?

- Summer Street Community Clinic – clinic for those who are homeless or perihomeless only

1.0 PCP encounter to 1.0 Psych NP encounter

0.6 PCP encounter to 1 counseling encounter

0.4 PCP encounter to 1 Total Psychiatric Encounter

More like a Primary Care Integrated Psychiatry Clinic as you would expect in the Homeless population

Penobscot Community Health Care

Conservative Estimate in Average Clinic

- Averaging our 3 largest PCP clinics with a mix of variables leads to 10 PCP encounters per 1 psych NP encounter.
- FT Psych NP may estimate 8.5 per day needed to break even which would be 85 PCP encounters in a day
- 19125 PCP encounters per year needed for 1
- This number decreases quickly with lower income, increased detection, lack of other resources, expanding uses in chronic disease and treating to 100% better

Penobscot Community Health Care

Group Synergism

- Med/Psych Chronic Disease – Obesity, DM, Fibromyalgia, Pain
- Educational
- Substance Abuse including"SmokeLess"
- Dialectical Behavioral
- Motivational Enhancement
- Change
- Parenting – Incredible Years
- Children - Dinosaur Group
- Cognitive Behavioral

Penobscot Community Health Care

What do patients think?

Penobscot Community Health Care

Patient Outcomes

- SF 12 – health survey measuring 8 domains
- Found patients improved from baseline in 7 out of 8 domains including Physical Functioning, Role – Physical, General Health, Vitality, Social Functioning, Role – Emotional, Mental Health
- Bodily Pain did not show improvement

Penobscot Community Health Care

Most Importantly – What do Patients Think?

"It's easier to get care when I need it"

"I know folks understand me and care about me"

Penobscot Community Health Care

Most Importantly – What do Patients Think?

"Because they all get to know all aspects of your life. They all know what meds you are on and can ask and tell what is wrong, even when you don't know what you might forget to ask"

Penobscot Community Health Care

Most Importantly – What do Patients Think?

" For me, the best part of this is that we rarely need just psych or just medical services. Often – as in my case – we have interconnected medical issues. 'Physical' health issues that effect psychiatric health or vice versa"

Penobscot Community Health Care

Most Importantly – What Do Patients Think?

" By having both services together and connected, it is far easier on the patient to get coordinated services which helps to get to the root of the problems, and more quickly!"

Penobscot Community Health Care

Most Importantly – What Do Patients Think?

"I knew that my PCOS/hormone issues were affecting my depression, but in the past I was forced to be the point person between two doctors who had absolutely nothing to do with each other. Very difficult. This process has become a breeze now and takes the burden off of me, which lets me concentrate on getting better."

Penobscot Community Health Care

Penobscot Community Health Care